



Release of Information

1. I am completing this form to allow the use and sharing of Protected Health Information about:
Printed Name: _____ Date of Birth: _____

2. I authorize _____ to use, receive or disclose the following information:

- Treatment Summaries History Evaluation Reports Discharge Summaries
- Medical/Medication Treatments Progress Notes/Update Recommendations
- Any related information for psychological/behavioral health

3. Dates of care includes:
 All through ____/____/____
 ____/____/____ to ____/____/____

4. To / From (Circle one or both): _____
Address: _____
Phone: _____ Fax: _____

5. The information will be used/disclosed for the following purposes:

- Continuity/Coordination of Care
- Responding to Family Concerns
- Referral

- 6. I understand this authorization is valid for 1 year from the date of signing or until revoked. I understand after the date or event; no more information can be released to the person or organization unless I sign a new authorization.
- 7. I understand I can cancel this authorization in writing. A letter will prevent any release of information after the date it is received, but cannot change the fact that information may have been released before that date.
- 8. I understand I do not have to sign this authorization and my refusal to sign will not affect my ability to obtain treatment or affect my eligibility for benefits. If a refusal does affect my treatment or benefit, I will be notified immediately.
- 9. I understand that I may inspect and have a copy of the health information described in this authorization.
- 10. I understand if a person or entity receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

Signature of Client (or Personal Representative) _____
Date

Printed Name of Client (or Personal Representative) _____
Relationship to Client

Description of Personal Representative's Authority

I, a health professional, have discussed the above issues with the client. My observations of his or her behavior give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of Professional _____
Printed Name of Professional & Date